NEW ZEALAND

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Synopses

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From New Zealand Society of Dentistry for Children to the New Zealand Branch of the Australian and New Zealand Society of Paediatric Dentistry – Our First 40 Years

Based on a paper presented at the Annual Study Day of the New Zealand Branch of the ANZ Society of Dentistry for Paediatric Dentistry, Wellington, 16 November 2013.

Harvey Brown

We have come a long way since the founding of what started out as the New Zealand Society of Dentistry for Children just over 60 years ago. It has been an interesting journey: initial strength followed by doom and gloom but, in more recent years, development into a society that is strongly supported, internationally connected, and of great relevance to the oral health scene.

The definitive history of our society is yet to be written, but here I am focusing on our first 40 years, with several themes to illustrate where we have come from, and how we got to where we are now. My sources are mainly the Minutes of our Society, faithfully kept over the years, and my own understanding of events, with a few additional memories thrown in.

The Beginnings

The inaugural meeting of the New Zealand Society of Dentistry for Children took place in Wellington on 1 September 1953. The meeting was convened and chaired by Professor George Davies, Head of the Department of Preventive and Children's Dentistry at the Dental School, University of Otago; George was later to become Dean in Brisbane and Pro-Vice Chancellor (Academic) of the University of Queensland. Seventeen others were there, including a strong contingent from the Dental Division of the Department of Health, one of whom, Dr Geoff Leslie, was elected Chairman. Subscription was set at £1. Links were established with the American Association for the Advancement of Dentistry for Children, a twice-yearly bulletin was planned, The American Journal of Dentistry for Children was to be circulated amongst members, and a diagnostic service for problem patients was to be offered to members.

A strong attendance of 46 was at the second AGM held in Auckland in September 1954. A significant suggestion was the preparation of a list of members willing to treat children with problems beyond the scope of the School Dental Nurse. First step was to gain approval from the then Central Executive of the New Zealand Dental Association, and this seemed to have been given by the time of the 1956 AGM. That meeting agreed to notify Branch Secretaries 'the names of members specially qualified to undertake treatment beyond the scope of School Dental Nurses'. This information was to be available only to members of the NZDA, suggesting that any such list of dentists was not generally available to school dental nurses for direct referral.

The system was certainly well-intentioned, but it never came to fruition. The Minutes of the Committee of the Society in June 1957, contained the terse statement: 'Certain information was made available regarding the policy of the Health Department regarding the official reference of patients to specific practitioners for treatment beyond the scope of school dental nurses'. The matter was discussed at length and it was decided to promote it no further.' No mention of the scheme

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appears in the AGM Minutes later that year, 1957, so it must have been heavily jumped on somewhere – my guess is that it was perceived on high as advertising or self-promotion. A major topic within Dental Jurisprudence in my Final Year at the Dental School in 1956 was the Advertising Regulations. At that time, advertising could be little more than a brief newspaper announcement of commencing practice, and strictly limited size of lettering on surgery windows. Practitioners promoting themselves as having special skills were very naughty indeed.

That 1957 AGM, incidentally my first, showed that the Society was on a roll. Although the purchase of a typewriter for the Secretary's use was not approved, Newton Wickham generously offered the services of his nurse to assist with any typing. And the Society's offer of a prize for a student in the Department of Dentistry for Children had been accepted by the University Council.

Hospital and private practice

The name C McG Littlejohn appears in the Minutes of the 1958 AGM. Mac was a remarkable fellow, who struggled hard to make a living as our first full-time specialist paedodontist, and also was to struggle hard keeping our Society afloat. He was Secretary-Treasurer in 1958 and became President for the first time in 1959.

In the Minutes of that 1959 AGM, attended by 23 members, business included the motion that a box of cigars be presented to the Dental School Librarian for organising circulation of journals. But a more significant topic raised was the suggestion that we join with the Orthodontic and Periodontal Societies in a joint meeting in off-Conference years (NZDA Conferences were biennial in those days), and this proposal was confirmed at the 1960 AGM. The first such meeting took place at Wairakei in September 1961, with 14 members attending.

A larger attendance was at the AGM during the Dunedin Conference in 1962. Notable at this meeting was the first mention of people with disabilities, when Harvey McClymont from the Dental School spoke on 'The Handicapped Person – a Broad Outline of the Types and Treatment'. This paper, which also included a tape recording by George Davies on his experiences in this field overseas, created a lot of interest, and could well have been the first on this topic ever presented at a meeting or conference in New Zealand. Harvey did great work for children with disabilities, and his work at the School was much appreciated by parents. He had what some of us thought was a rather tricky process of dressing teeth of children under nitrous oxide anaesthesia, which was given by (Professor) Sandy Macalister – day-stay endotracheal general anaesthesia for restorative care at Dunedin Hospital was to come a little later. Harvey also used sedation extensively, and he is reported as saying in his paper that 'when drugs are used, it is essential to be thoroughly familiar with their action' and that 'The need for sedation decreases as the experience of the operator increases', which I think we would all agree with. Harvey never took office in the Society, but his work for the care of children with disabilities was widely acknowledged. Subscriptions, incidentally, are still £1.

Mac Littlejohn was re-elected President at the Wairakei meeting of 1963, where he opened discussion on hospital dental services for children, referring to a submission made by the Society. I don't recall what this contained, but I clearly remember Mac's frustration over the lack of such services. He had a part-time Auckland Hospital appointment at this time, but he was working under great difficulty. Although a recognised specialist in his own practice, he was expected to provide treatment for School Dental Service-referred patients, that is, children with all sorts of problems, at the Department of Health's Dental Benefit rates (rates for treatment by general practitioners of problems beyond the scope of the school dental nurse) – he was not able to charge anything over that, and parents were very reluctant to pay a reasonable private fee.

Two items at the Wairakei meeting in 1965 again showed the difficulty of providing care for children with disabilities. It was decided to send a letter to the Department of Health 'requesting automatic enrolment for Dental Benefit purposes of intellectually handicapped children who have been unable, in the past, to obtain treatment'; and Mac Littlejohn discussed further submissions on hospital dental services and the possibility of a subsidy for the treatment of handicapped children.

My early postgraduate experience had been as Resident Dental Officer at New Zealand's largest residential institution for the intellectually disabled, the Levin Hospital and Training School. By this time, 1965, I was back at Levin after my studies at the University of Illinois, and I was being approached by parents of children from outside the hospital, frantic because of inability to obtain care – at that time there was no Mac Littlejohn or Harvey McClymont in the southern parts of the North Island. The Intellectually Handicapped Children's Society and the Crippled Children's Society were working hard to improve the situation, but it was a very unfortunate period.

At the 1967 AGM, the possibility of the Society, now known as the NZDA Society of Dentistry for Children, first discussed the possibility of sponsoring a course for general practitioners on the care of children with disabilities. The first of two courses I ran on behalf of the Society at the Levin Hospital and Training School was in July 1968, with the full support of the then Divisions of Dental Health and Mental Health of the Department of Health; and the second was in November 1973, some 3 years after I had left the Hospital for Dunedin. Both courses were very well received, certainly by practitioners who had never experienced treatment of children under endotracheal GA.

Coming back to that meeting in 1967, President Mac Littlejohn reported on his meeting with members of the Australian Dental Association and of the efforts being made to form an Australian Society of Dentistry for Children. At this time we were going along quite nicely with 12 members at Wairakei and a healthy list of apologies, so there was no thought then of any future formal liaison with our Aussie colleagues.

Efforts to gain additional reward for treating children with disabilities was gaining momentum, with support coming from NZDA for dentists being able to charge an additional fee over the Dental Benefit fee. This never happened though – no doubt the suggestion was viewed by the Dental Benefits Advisory Committee as a can of worms that, once opened, could never be closed. Poor Mac just struggled on for meagre reward and, I believe, to the detriment of his health.

Down but not quite out

Two items of interest are noted at the 1968 AGM – I became President for the first time, and Dick King from the Dental School was pushing the Surgical Trades Association to get cracking on importing stainless steel crowns – we were using them and teaching their use at the School, but they were very hard to get, and this problem continued for some years.

In the early 1970s we were struggling for members, so much so that, at 1975's AGM

at Wairakei, the only member present was the President, Betty de Liefde. Not surprising, then, that she suggested in her 1976 Annual Report we should consider going into recess. All seven of us present at that meeting had a good discussion on the proposal – the Minutes tell me that I proposed we write to all our members telling them we were considering going into recess, and what are their thoughts? I also see that, if we were to go into recess, I suggested, very thoughtfully, that we keep back enough cash to continue with the Society's prize at the School, that we should meet again the next year at Wairakei, and that we increase the subscription to $3; but we didn't have enough cash to continue association with the IADC, the International Association of Dentistry for Children.

Only three members were present at that Wairakei meeting – Dave Dinniss (President and private practitioner), and Michael Hollis and Betty de Liefde, both of the Department of Health. They bravely decided to carry on, one reason being that the profession had to be seen to be interested in children's dentistry, and not abdicating all responsibility to the School Dental Service.

Next year's meeting was in Christchurch, only five present, but moral support came from unnrecorded members of the Australian Society of Dentistry for Children, and the meeting agreed that 'some effort must be made to keep the Society going'. I believe much credit here must go to David Dinness. I thought him to be a very gracious and compassionate person, who came to the second of my Levin seminars. However, we lost track of him when he left the profession and was subsequently ordained as an Anglican priest.

Things were looking up in 1980 when 13 of us were at the AGM in Dunedin. We re-joined the IADC, Clive Wright reported on progress within the Australian Society, which was hosting the Congress of the IADC in Melbourne, and we bravely raised the sub to $5!

But at the 1982 meeting there were still doubts about whether we should continue. I suspect Allan Isaac saved the day in his contribution to the discussion, but then, later in the meeting, came the first serious move to change the Rules in order to bring in Associate Members, the school dental nurses. The Minutes record fully the nature of the discussion – some in favour as revitalising the Society, others dead against, some on the grounds that dental nurses, if admitted, could be perceived as being equal with dentists, and even taking over the Society in the future.

The motion to include Associate Members was lost, but was raised again, and lost again, at the 1984 meeting where 21 members were present – including, for the first time one BK Drummond. I was somewhat surprised to see in the Minutes of that 1984 meeting that 'RH Brown was keen to see closer association with the Australian Society of Dentistry for Children, even to the point of our forming an ANZ group'. Peter Ashton was going to be at the Australian meeting, and he was to be asked to initiate some form of liaison.

In my 1986 Presidential Address I made the point that, if we failed to achieve some association with the Australian group, we should allow our Society to 'die a natural death'. A discussion on this waxed and waned, until finally, and even after what reads like an impassioned speech from Allan Isaac, a very pessimistic motion for the Society to cease at the next AGM was passed.

However, Alan was asked to represent us at the next Australian Society's Congress. The outcome proved very positive, as reported at our 1988 AGM, for the motion for us to cease was not even discussed. Instead we passed the motion 'That the NZDA Society of Dentistry for Children be reconstituted as the New Zealand Branch of the Australian and New Zealand Society of Paediatric Dentistry'. A Steering Committee consisting of Peter Ashton, Bernadette Drummond, Alan Isaac, and Geoff Lingard was appointed to sort out the details.

Incidentally, from that meeting we sent a letter to Dick King marking his retirement from the Faculty of Dentistry and, although it was not mentioned in the Minutes, I believe that was when we elected him an Honorary Life Member. We also congratulated Bernadette on her appointment to the Department of Community Dental Health, and welcomed her back to New Zealand.

And having her back has been of huge importance to us. I believe a turning point in New Zealand Paediatric Dentistry came when this young student at the School came to Dick and I asking if she could do an elective with us in her Final Year. That was easily answered, and Bernadette had a great elective, won our Society's Prize, went on to higher degrees overseas, academic appointment at Leeds and, to our delight came back to Otago. Here her enthusiasm, energy and commitment have raised the profile of Paediatric Dentistry and her influence is seen in this room today with many of you having been inspired to make our discipline your career and life-long interest.

Bernadette we honour you.

The new enthusiasts

We survived the very difficult 1980s when we tried to maintain relevance, and wrestled with membership issues, including the vexed question of Associate Members. The ray of hope was the prospect of becoming a properly constituted branch of the ANZ Society of Paediatric Dentistry, and that indeed was achieved.

There are no formal Minutes between the AGM's of 1988 and 1994, but there definitely had been a meeting in 1992. And there was plenty going on. The 1994 Minutes reveal a completely different atmosphere. Bernadette was President and Councillor to the ANZ Society of which we were by then a full Branch; we had a new Constitution; our little Bulletin had now been replaced by the up-market and very informative Synopses; new names appearing included Callum Durward, Craig Waterhouse, Mary Livingston, Christine Holloway, Ian Esson, Mary-Anne Costelloe, Robyn Whyman, John Strange, Stephanie Wills. Courses by overseas clinicians Professor Stephen Moss (New York) and Louise Brearley-Messer (Melbourne) had been held in 1992; James Lucas gave a 2-day hands-on course in 1993; Richard Widmer had been over from Australia taking part in a 1-day course; and we were to host the ANZSPD Conference at Queenstown in 1995. And, you pensioned off this old chap by making him an Honorary Life Member, a distinction I greatly treasure.

And later came further new names, people who have served and continue to serve our Society well – such names as Nina Vasan, Wanda Gaynor, Katie Ayers, Alison Meldrum, Heather Keall, Heather Anderson, Dorothy Boyd, Jo Pedlow, Kate Naysmith, Erin Mahoney, and so on and on. And an even newer generation is here today with more-recent graduates.

So that takes us briefly over the 41 years from 1953 to 1994. And there I conclude. Many of you know well the other 19 years of our 60, so I can confidently leave the rest to you, to be told on some future occasion.

I congratulate you all on rebuilding our Society into the vital, relevant, vigorous organisation it is today.

Federal President's Report

John Sheahan

As I sit here in Melbourne preparing my second report for Synopses in 2014, the winter chill is starting to lift and my thoughts are turning towards football's Finals Series and the Spring Racing Carnival.

While the football team I support, the Melbourne Demons, won't feature in the September final's action (actually, this year they are languishing near the bottom of the league ladder), I am pleased to report that, as a fourth generation supporter, my allegiance is as strong as ever. In the same way, my determination to advocate on behalf of the oral health of the infants, children and adolescents of Australia, New Zealand and indeed the wider south-west Pacific region continues unabated. In this quest, I am buoyed by the support I receive from ANZSPD's Federal Councillors, the Branch Executives and Committees and our grass roots Members, all of whom have contributed to the smooth running of ANZSPD.

In the very first President's Report that I wrote for Synopses back in 2012, I called on every member of ANZSPD to play a role in this advocacy and I listed a number of ways in which each member could contribute. The first I stated was:

"Voting in favour of ANZSPD members who are nominated for professional committees is the simplest role every member can play. It usually only requires a tick in a box and a postage stamp to vote."

We are fortunate that two members of ANZSPD, Dr Peter Gregory and Associate Professor Nicky Kilpatrick, are Councillors of The Royal Australasian College of Dental Surgeons (RACDS). Their term in office is drawing to a close. I understand both are considering standing for election to the College Council (2014-2016). I encourage eligible members of the College to support their continued involvement by voting for them in the RACDS election. Both have a long history of successfully advocating on behalf of the oral health of infants, children and adolescents, are tireless workers, and are great contributors to ANZSPD.

As you are aware, ANZSPD was actively involved in providing input to the Australian Government during the planning and implementation stages of the Child Dental Benefits Schedule (CDBS). The CDBS is now fully operational in Australia and will have been utilized by members of the local Branches on behalf of their patients. While ANZSPD welcomes the extra public money made available through the CDBS for the oral care of infants, children and adolescents, it is disappointing that the Australian Government's 2014 Federal Budget has proposed the tightening of the eligibility criteria for Family Tax Benefits, and in turn for the CDBS. As a result of this proposal, many well-deserving patients will find themselves locked out of the CDBS.

One of ANZSPD's most recent submissions was to the Dental Board of Australia (DBA) in response to the Board's review of its registration standards and guidelines. Once again, I am pleased to acknowledge the significant input supplied by ANZSPD's broader membership which resulted in a carefully considered submission reflective of the views of the Society's membership as a whole. In particular, I would like to acknowledge the outstanding contributions to the submission made by Dr Karen Kan and Associate Professor Nicky Kilpatrick.

On this occasion, not only did ANZSPD have its opinion heard through a direct submission to the Board, it also influenced the views expressed by the Australian Dental Association (ADA) in the ADA's own submission to the Board. This improved ability of ANZSPD to influence the ADA resulted from a proposal initiated by ANZSPD at the recent ADA Affiliates' Meeting in Sydney, a meeting at which ANZSPD supported my attendance. In response to that proposal, the ADA has now put in place a formal consultation process with its Affiliated Societies so that Affiliates can contribute to the first draft and subsequent revisions of the ADA's own submissions. ANZSPD will no longer be in a position to complain that the ADA never consults the professionals at the coalface on issues related to the oral health of the infants, children and adolescents of Australia. In time, I trust that a similar relationship will develop between ANZSPD and the New Zealand Dental Association (NZDA).

As members of ANZSPD, our advocacy on behalf of the oral health of our young people does not have to be just via an ANZSPD submission. Earlier this year, my family and I had a relaxing private holiday in Fiji during which we had an opportunity to imbibe the local culture for the first time. We were privileged to travel on a small cruise ship to some very tiny communities on outlying islands where there have been limited opportunities for interaction with tourists and modern Western dietary norms. Access to fluoridated water in this part of the world is non-existent, and children have little or no access to basic dental care, either because of their relative geographical isolation or their family's financial situation. It was fantastic to meet these children who were incredibly happy, even though they lived in modest, to our eyes almost impoverished, circumstances. During cultural displays performed by the villagers for the benefit of passengers, confectionary on a stick was handed out by the ship's crew to the dancers while they were in the middle of their energetic routines. Distributed by the crew to show to the villagers the appreciation of the audience, the confectionary replaced the traditional sign of appreciation, which in Fiji is to smear sandalwood on the faces of the dancers. To its credit, the cruise line encourages passengers to bring onboard educational goods to donate to the schools in these villages. However, it was disappointing to see the cruise line inadvertently creating a choking risk for the dancers, increasing the risk of oral trauma from the stick, and corrupting the healthy dietary patterns of the local inhabitants by deliberately introducing confectionary into the diet of the population in general and children in particular. These children are among the least able in the south-west Pacific region to access preventive measures against the incidence of dental caries and to access basic dental treatment when it is required. I am reminded of the people of Tristan da Cunha, a population of British stock

on an isolated island in the South Atlantic, in whom the incidence of dental caries rose significantly in the 1930s when the arrival of shipping from abroad increased in frequency, resulting in an increased availability to highly cariogenic foods and the development of poorer dietary patterns. Suffice to say that the cruise line has received a letter from me asking that it show its appreciation of the efforts of the local population in more traditional ways and cease giving out confectionary to the population. I encourage each of our members to speak up as individuals in the same way if they see an opportunity to advocate on behalf of the oral health of infants, children and adolescents.

During the last year, ANZSPD has developed a strong relationship with the Australian and New Zealand Academy for Special Needs Dentistry (ANZASND) and the Australian Society for Special Care in Dentistry (ASSCID). The challenges affecting members of ANZASND and ASSCID are often the same as those affecting ANZSPD's members and we have found ourselves singing from the same songbook in political fora on more than one occasion. This synergy between our organizations has amplified our message and given us greater leverage to influence key organizations which control how we deliver dental care to our respective patients. At the same time, ANZSPD's already strong relationship with the Australasian Academy of Paediatric Dentistry (AAPD) has been nurtured and it continues to be mutually beneficial to both organizations.

Earlier this year, the ANZSPD (Vic Branch) organized the 2014 RK Hall Lecture Series on behalf of our federal body. Professor Svante Twetman and Associate Professor Michael Casas proved to be both entertaining and informative, and the meeting was highly successful from an educational, collegiate and social point of view. Once again, we owe a deep debt of gratitude to Colgate, our major corporate partner. Without Colgate's financial assistance, a meeting of this size and quality would be impossible to present for Members and non-members alike. ANZSPD is also grateful to ANZSPD's other corporate partners which supported our Exhibition and contributed to the cost of the entertainment at the Gala Dinner. I would also like to acknowledge all of the Members of the Local Organising Committee, whose endeavour resulted in the success of the meeting. In particular, I would like to thank Dr Karen Kan and Dr Evelyn Yeung, who were respectively President and Secretary of our Victorian Branch in the months leading up to the Lecture Series, for their outstanding contribution to its organization.

ANZSPD was honoured that Mrs Helen Devlin and Mr Richard Devlin accepted its invitation to be its guests at the Dr Alistair Devlin Memorial which was held during the course of the Lecture Series. A moving tribute to Dr Devlin, acknowledging his contribution to ANZSPD, was presented by Dr John Winters. Mr Devlin responded on behalf of the family, giving us further insight into the wonderful man we all miss so much. Alistair may have passed from this life, but his wicked sense of humour and irreverence lives on in Richard, who left us smiling at the end of his response. At this Memorial, I had the pleasure to announce that it had been decided that the existing ANZSPD Grant was to be renamed The ANZSPD Alistair Devlin Memorial Grant in honour of Alistair's memory and to acknowledge his most significant contribution to ANZSPD.

Federal Council met in Melbourne before the start of the 2014 RK Hall Lecture Series. I am most grateful to the Federal Councillors for their wisdom and diligent attention to the duties of their office during the past year. Thanks to the meticulous organization in advance of the meeting by Dr Peter Gregory, ANZSPD's Federal Secretary/Manager, the meeting's long agenda was dealt with efficiently and effectively. I am pleased to report and most grateful that Dr Gregory has agreed to continue in the role of Secretary/Manager until ANZSPD's next AGM which will coincide with both the end of my term as Federal President and with the next Federal Scientific Meeting, which is to be held in Adelaide in November, 2015. Dr Gregory is continuing to do a sterling job in a position he never sought. He has proven himself to be a great support to ANZSPD in general and to me in particular in my role as President. Dr Gregory has advised Federal Council that he will be retiring from his current position at the next AGM and he has recommended that the position of Secretary/Manager be split into two positions to lighten the administrative burden on the incumbent.

ANZSPD's South Australian Branch under the leadership of Branch President, Dr Michael Malandris, is busy planning the next Federal Scientific Meeting which is to be held in Adelaide 12th – 15th November, 2015. Arrangements are already well progressed. This meeting will coincide with the 25th Anniversary celebration of the AAPD and promises to be well-attended.

Generating enough suitable material for publication in Synopses has been a problem which has bedevilled the last few Editors. It has been disappointing that so few editions have been published during my presidency. As Editor, Dr Tim Johnson is to be congratulated on the dogged determination he has shown while editing Synopses on the Society's behalf, especially as a dearth of material has been available for publication. At Federal Council's meeting earlier this year, it was decided that in future each Branch will take in turn responsibility for generating material for Synopses. I am pleased to report that the New Zealand Branch took on the challenge to supply material for this edition. Following the next special issue of Synopses, planned for publication in 2014/2015, is the responsibility of the Western Australian Branch.

It is customary for the Federal President to attend a scientific meeting run by each Branch during the Federal President's term in office. Such is the importance of this custom that the main costs associated with the Federal President's attendance are borne by ANZSPD's federal body. In July, I had the pleasure of participating in my first Branch meeting outside Victoria when I was invited to the Western Australian Branch's Midwinter Meeting which was held at Bunker Bay about 260km south of Perth. This annual meeting commenced at lunchtime on Friday and finished at lunchtime the following day, giving delegates the opportunity to travel to the meeting on Friday morning and to spend the rest of the weekend enjoying the local hospitality before returning home to commence work first thing on Monday morning. I was impressed by the quality of the presentations made by the local speakers and was pleased to get to know the delegates, some of whom were accompanied by family members. The meeting's informal atmosphere and convivial surrounds enhanced both the learning opportunities and the fellowship shared. Once again, I would like to extend my thanks to the WA Branch for its kind invitation and offer my congratulations to the Branch Committee under the leadership of the Branch President, Dr Peter Readman, for running such a wonderful meeting so seamlessly. I look forward to attending the remaining

Branches before my term as Federal President is completed in Adelaide in November, 2015.

I am also looking forward to attending the 25th Congress of the International Association of Paediatric Dentistry (IAPD), which is to be held in Glasgow, Scotland from 1st July to 4th July, 2015. Outlines of the scientific and social programmes are now available and the event is shaping up to be one of the best IAPD Congresses yet. Registration is now open and further detailed information about the Congress is available on the website: www.iapd2015.org

Many of you will be aware that the ANZSPD website crashed last year. Since then, the Federal Council has budgeted for the development of a revitalized website and Members had their first glimpse of it during the 2014 RK Hall Lecture Series. I am most grateful to Dr John Winters who has coordinated its development on behalf of ANZSPD. I am sure it has already taken him many hours of work to get it to this stage and I thank him for his efforts. I would also like to thank Associate Professor Nicky Kilpatrick and her working party of enthusiastic contributors for the wonderful material they have produced for publication on the website. It is hoped that the website will be fully operational in the near future.

As I enter my third year as Federal President, I trust that I will continue to receive the support of the general membership, the Branch Committees and the Federal Council in progressing the aims of ANZSPD for the benefit of the infants, children and adolescents of Australia and New Zealand.

Federal President

ANZSPD Inc.

Presidential Report New Zealand Branch

Heather Anderson

It is our pleasure to be providing the material for this NZ synopsis. If all the branches accept this task with the same enthusiasm, then we should have some great reading in future issues.

I am somewhat privileged to be the NZ branch president at this time. Last year was 60 years since the NZ Society of Dentistry for Children began. In November we held our 7th Annual Study Day in Wellington and were graced with the company ofour previous members, Dr's Grace Suckling and Betty de Liefde. Grace, in her 90's, provided us with a very entertaining presentation on her early research on enamel defects, and Harvey Brown gave us the history of 60 years of the NZ Society of Dentistry for Children. Kelsi Ander, the recipient of the Sir John Walsh summer Student scholarship from the ANZSPD NZ Branch provided a presentation of her research, "A Literature Review of Adolescent Oral Health in NZ". It was a very successful summer studentship addressing an area of interest for our branch. She had worked extremely hard and gave a fantastic update in her presentation. Anna Ferguson spoke on Childhood Obesity and oral health, lifestyle behaviours and related co morbidities. Colleen Murray reported on Child maltreatment – knowledge of NZ dental therapists and we finished with a number of excellent postgraduate presentations. It was such a fantastic day having both spectrums (retired and new graduates) of the society present.

At the study day we also acknowledged Assoc Prof Richard (Dick) King. A tribute to him was provided by Dr Harvey Brown. Assoc Prof King was a founding member of the NZ Society of Dentistry for Children in 1953. He was president of the NZDA in 1979 – 1980 and was a foundation member and former President of the Royal Australasian College of Dental Surgeons. He was awarded Honorary Life Membership to both. Dick contributed tirelessly to the dental profession and to community organisations throughout his life.

Many NZ members attended the RK Hall Lecture Series in Melbourne back in February. This was an excellent couple of days and well received by all who went

As I am writing this, the NZDA conference is again, after a few years, in Christchurch this year, August 20-23. We are excited to have Dr Peter Readman joining Dr Erin Mahoney presenting "Comprehensive restorative management of the primary and mixed dentition". The NZ branch has sponsored Erin for this session so will be great to have a presence and the ability to raise the profile of ANZSPD. I am really looking forward to this meeting.

Well I don't know where this year has gone, Christmas seems just around the corner.

Best wishes to all and enjoy our issue.

SEAL CAMBODIA – an innovative caries prevention program in Cambodia

Callum Durward[1], Katie Bach[2], David Manton[2], Bathsheba Turton[1], Sopharith Soeun [3], Sithan Hak[3], Tepirou Chher[3], Rasy Soy[4]

1 University of Puthisastra, 2 Cambodia; University of Melbourne, Australia,
3 Ministry of Health, Cambodia, 4 International University, Cambodia

Abstract:

There is a high prevalence and severity of dental caries amongst Cambodian children, with the mean dmft being 9.0. The SEAL CAMBODIA project was initiated by the Global Child Dental Fund, with support from CamKids (The Cambodian Children's Charity) and GC Asia. The funds provided by the ANZSPD have provided a motor bike with a carriage ("tuk tuk") which has been very helpful for transporting the teams and equipment from school to school.

The aim of the project is to place fissure protection using Glass Ionomer Cement (GIC; Fuji 7) on the first molar teeth of 60,000 Grade 2 children over three years. Tooth brushing instruction and oral health education are also provided. During the first year, approximately 20,000 children were sealed. The local partners in the project include the Cambodian Dental Association, International University, the Dental Nurses School and two NGOs, One-2-One Cambodia and Cambodia World Family. The Ministry of Health, and the Ministry of Education, Youth and Sport (MOEYS) are also involved. A protocol for the project has been developed, and all members of the SEAL teams undergo training. These include local and international dentists, dental therapists, dental hygienists, dental assistants and dental students. Alongside the main project, a research study is being carried out on 600 children over the three years to determine the effectiveness and acceptability of the intervention.

Introduction

The high burden of dental caries in Cambodia has been recently highlighted by the 2011 National Oral Health Survey by the Ministry of Health in Cambodia (Chher et al, 2011), which found that the average 5-to 6-year-old child in Cambodia had a dmft of 9.0 (Table 1). This ranks among the highest levels of decay in the world. Furthermore, the lack of dental treatment is demonstrated by the high d/dmft ratio and the number of pulpally involved teeth. The mean pufa score (Monse et al. 2010) showed that the mean number of pulpally involved teeth for 5-to 6-year olds was 2.7. The permanent teeth most affected by decay were the first molars, primarily the occlusal surfaces. At ages 12 and 15, the DMFT was 3.5 and 4.2 respectively.

Previous studies have observed that caries in Cambodian children starts at a young age, and it has been suggested that this may be related to a high sugar diet, harmful infant feeding practices (including prolonged on-demand nocturnal bottle- and/or breast-feeding), a lack of oral hygiene and a lack of fluoride (Chu et al. 2008; Shidara et al. 2007; Turton et al, in draft).

Table1: Dental status of children and adolescents in Cambodia[a]

Age Group (years)	Caries free (%)	d teeth	m teeth	f teeth	dmft	pufa	D teeth	M teeth	F teeth	DMFT	PUFA
6	6.9	8.9	0.1	0.0	9.0	2.7	0.2	0.0	0.0	0.2	_
12	21.7	–	–	–	–	–	3.4	0.1	0.1	3.5	0.9
15	19.6	–	–	–	–	–	3.8	0.1	0.2	4.2	1.0

[a] adapted from Chher et al, 2011

The low 'filled' component of the dmft/DMFT reported in the 2011 national oral health survey shows that most Cambodian children had not received prior dental treatment (table 1). Further analysis showed that most dental visits were for "relief of pain". There is no national school dental service in Cambodia; however several preventive dental programs have been established in some schools over recent years, mostly in Phnom Penh. These include the Bright Smiles Bright Futures (BSBF) project, the Fit for School (FFS) project, and the Live Learn Laugh (LLL) project.

1. Bright Smiles Bright Futures (BSBF)

Since 2008, BSBF has operated in Cambodia with the support of the Colgate Palmolive Company. The program includes the provision of toothpaste, toothbrushes, and educational materials (e.g. tooth brushing models and posters) to approximately 500 primary schools. BSBF is a collaboration between: the Oral Health Office, Preventive Medicine Department, Ministry of Health; the School Health Department, Ministry of Education, Youth and Sport, and the Colgate Palmolive Company. The program started in Phnom Penh, but has now spread to 10 provinces. It focuses mainly on children in Grades 3 and 4 with brushing instruction and oral health education. Recently, in addition to the preventive dental interventions, the BSBF also includes hand-washing instruction and practice. These activities are introduced through a "training of trainers" (TOT) approach involving school teachers and health workers. To date over 300,000 children have participated in this program.

2. Fit for School (FFS)

Fit for School is a program which focuses on improving both general and oral health (Monse et al. 2010 b). It originated in the Philippines, and is now also operating as

a pilot project in Cambodia, Laos and Indonesia. There are three components: daily hand washing with soap; daily tooth brushing with fluoride toothpaste (1450ppm); and biannual de-worming. Both hand hygiene and tooth brushing are carried out as group activities so that children will develop both good habits and a good attitude toward their health. One of the key elements of the program is to create a supportive environment at school through:

- Improving access to water
- The construction of hand washing and tooth brushing facilities
- Creating a Health Corner in the school.

The FFS program in Cambodia is a collaboration involving the Oral Health Office, Preventive Medicine Department, Ministry of Health, the School Health Department, Ministry of Education Youth and Sport, the Parent Teacher Association (PTA), local authorities, and the German International Cooperation (GIZ). To date, 10 schools are involved in the program – 2 schools from Phnom Penh, and 8 from the provinces. Following the initial pilot project lasting 3 years, it is hoped that the program can be rolled out to schools all over Cambodia in the future.

3. Live, Learn, Laugh (LLL)

This project is a global partnership between Unilever Oral Care, the FDI World Dental Federation, the Cambodian Dental Association, and the Oral Health Office, Preventive Medicine Department, Ministry of Health. It aims to measurably improve oral health in children through encouraging school students to brush twice daily with a fluoride toothpaste. The project was first implemented in 2005 and involved 8 primary schools in Phnom Penh. In the near future this number will increase to 10 schools.

SEAL CAMBODIA

Even with the preventive school programs described above, occlusal decay affecting the first molar teeth continues to be a significant problem. Studies have shown that the most effective way of preventing pit and fissure caries of the permanent molars is through the use of pit and fissure sealants. There are two types of sealants widely used by dentists today. The first are the resin sealants, which have good long-term retention. However these should only be placed on fully erupted molars, and where excellent isolation can be achieved. There is generally a requirement for these sealants to be placed where suction and air/water spray are available.

The second type of "sealant" is the glass ionomer cement (GIC) sealant. This is also referred to as "fissure protection". Studies show that even though there is earlier loss of these sealants from the teeth compared with the resin sealants, the caries increment after 3 years is similar (Poulsen et al 2006). This is thought to be due to the release of fluoride from the GIC into the pits and fissures of the tooth, and possibly to the retention of a small amount of the GIC deep in the fissure, after the bulk of the sealant is lost (Poulsen et al 2006). Unlike the resin sealants, GIC sealants can be placed in situations where there may be no suction or air/water spray available, and also on partially erupted teeth. GIC sealants are more suited to school-based programs where dental equipment and even electricity may be lacking.

Two years ago the Global Child Dental Fund (GCDF) Taskforce in Cambodia, made up of many of the local dental stakeholders working to promote child oral health, proposed the SEAL CAMBODIA project, and established a target of sealing 60,000 grade 2 children with GIC over a three year period. The proposal was accepted by the Ministry of Health, and the Ministry of Education, Youth and Sport. Funding was provided by GCDF, CamKids (The Cambodian Children's Charity), and GC Asia (which also donated the GIC – Fuji VII). The ANZSPD also made a generous donation in the first year enabling the purchase of a tuk tuk to transport local and overseas volunteers to go to the schools around Phnom Penh.

SEAL CAMBODIA was launched in late 2012 and a number of partners were invited to participate including: the Cambodian Dental Association; the Dental Nurses School in Kampong Cham; the Faculty of Dentistry at International University; One-2-One Cambodia (a registered NGO which also houses the Beacon Center of the GCDF, and coordinates the project); and Cambodia World Family (NGO). Since then the Cambodia Buddhist Library Project (an NGO) has joined, and the University of Health Sciences and the University of Puthisastra have indicated their intention to become involved later in 2014. The dental students and dental personnel from these organizations, along with many overseas volunteers, are making a significant contribution to the project; however, more volunteers and support are needed in order to reach the final target.

How SEAL CAMBODIA works

A protocol for training was developed and tested, and since then all clinicians and assistants have been trained in the procedures before they begin. Each partner organization is allotted certain schools to seal by the MOEYS. One of the SEAL team staff contacts the principal of the school to explain the project, and seek permission for a dental team to visit. An information and consent form is sent home to the parent, who has an opportunity to decline the sealants if they wish. Each SEAL partner was initially provided with sets of instruments and materials. Once 100 children have been sealed, the partner is provided with a new set of materials for the next 100.

The basic SEAL unit is made up of three people: an educator, who registers the child, provides dental health education, and supervises the child brushing their teeth; a dental assistant, who sets up the instruments and materials, mixes the GIC and manages the cross-infection control; and an operator, who places the fissure protection. The operator may be a dentist, dental student, dental therapist, or dental hygienist.

Once the SEAL team arrives at the school, the Grade 2 children are taken from the class in small groups. They are firstly given a toothbrush and asked to brush their teeth, while being given oral hygiene instruction by the educator. They are also given some important oral health education messages. Next they are examined in the supine position using a head lamp on a portable dental chair or a school desk. The caries and eruption status of their first molars are then recorded on the examination form. Teeth for sealing are identified and the fissure protection is placed.

The material used for sealing is hand-mixed Fuji VII (pink; GC Corp Japan). The basic procedure is: (1) the teeth are cleaned and debris removed; (2) the dentine conditioner is applied and then removed with a wet cotton pellet; (3) the tooth is dried using cotton pellets; (4) hand mixed Fuji VII is mixed, placed into the tooth, and pressed into the fissures using the operators' lubricated finger, which is held in place for 30sec. The child is asked not to eat or drink anything or bite on the

tooth for at least one hour. The child is sent home with a leaflet for the parent explaining what was done, whether treatment from a dentist is needed, and giving some important oral health messages. The project employs a dentist to support and monitor the partners, provide administrative assistance, and give training where needed.

To monitor the effectiveness and acceptability of the SEAL CAMBODIA project, a research group (including several dental academics from Australia, NZ, Cambodia, and the United Kingdom) was formed. They have designed a three-year comparative study of 400 children in an intervention group (sealed), and 200 children in a control group (not sealed). Ethical approval was obtained from the Cambodian National Ethical Committee for Health Research.

Progress so far

Between December 2012 and April 2014, approximately 24,000 children were sealed. On April 3 2014 a celebration to recognize this milestone was held at the Santhor Mok Primary School in Phnom Penh. Two Secretaries of State from the MOH and the MOEYS attended, along with the SEAL donors (GCDF, CamKids and GC), SEAL partners, and about 1000 children. The celebration included speeches, singing, dancing, gymnastic performances and a SEAL demonstration. The event was broadcast on 3 television stations and reported in 3 newspapers. The Cambodian Ministries have been very happy with the project so far.

SEAL CAMBODIA has the potential to be hugely beneficial for Cambodian children, and could prevent the extraction of many thousands of first permanent molars. However, to achieve our goal of sealing 60,000 children, more overseas volunteers are wanted to help. In order to make volunteering an attractive option for volunteers, the SEAL CAMBODIA team can arrange complete participation packages. These packages can include airport pickup/drop off, accommodation, transport, sight-seeing and of course participation in the SEAL CAMBODIA project. Most volunteers come for one to two weeks, and take the opportunity to explore the country's ancient past and unique scenic attractions.

Conclusions

Cambodian children suffer from a high burden of dental caries and there have recently been a number of programs aimed at reducing this burden - including the SEAL CAMBODIA project. The SEAL CAMBODIA project has been successfully implemented and 20,000 children have been sealed in the first year. It is a good demonstration of how different groups, both local and international, can work together to make a significant difference in the health of Cambodia's children. Volunteers are invited to join with us in reaching our goal of sealing 60,000 children over the three year period of the project.

References

- Chu, C.H.; Wong, A.W.Y.; Lo, E.C.M.; Courtel, F. (2008): Oral health status and behaviours of children in rural districts of Cambodia, International Dental Journal 58:15-22.
- Durward, C.S. (2013): NGO Initiatives and Impacts on the Oral Health of School Children in SE Asia. The 7th Asian Conference of Oral Health Promotion for School Children, Sept 12-14, 2013, Bali, Indonesia, pp 50.
- Chher, T.; Hak, S.; Beltran, E; Hobdell M.; Courtel, F. Ministry of Health, Cambodia (2011).National Oral Health Survey, 2011.
- Monse, B.; Heinrich-Weltzien, R.; Benzian, H; Holgren, C.; van Palenstein-Helderman, W. (2010a): PUFA – An index of clinical consequences of untreated dental caries. Community Dent Oral Epidemiol 38:77-82.
- Monse, B.; Naliponguit, E.; Belizario, V.; Benzian, H.; and van Palenstein-Helderman, W. (2010 b): Essential health care package for children - the 'Fit for School' program in the Philippines. International Dental Journal 60: 85–93.
- Poulsen, S.; Laurberg, L.; Væth, M.; Jensen, U.; Haubek, D. (2006). A field trial of resin-based and glass–ionomer fissure sealants: clinical and radiographic assessment of caries. Community dentistry and oral epidemiology, 34(1), 36-40.
- Shidara, E.K.; McGlothlin, J.D.; and Kobayashi, S. (2007): A vicious cycle in the oral health status of schoolchildren in a primary school in rural Cambodia. International Journal of Dental Hygiene 5:165-173.
- Teng, O.; Narksawat, K.; Podang, J.; Pacheun, O. (2004): Oral health status among 12-year-old childen in primary schools participating in an oral health preventive school program in Phnom Penh City, Cambodia, 2002. Southeast Asian Tropical Medicine and Public Health 35:458-462.
- Turton, B; Durward, C. Sociobehavioural risk factors for Early Childhood Caries in Cambodian children, 2014. (in draft).

Interceptive Orthodontics in a Patient with Down Syndrome. Case Report.

Kate Naysmith | Senior Dentist
Community Dental Department
Hutt Valley DHB New Zealand

Case presented as part of the requirements for the Postgraduate Diploma in Clinical Dentistry (Paediatric Dentistry)

Supervisors: Dr E Mahoney and Prof B Drummond

Introduction

Down Syndrome (DS) is a common genetic disorder, which affects 10 per 10,000 live births worldwide (Weijerman and de Winter, 2010) and is characterised by an intellectual impairment accompanied by a range of phenotypic anomalies including many dental anomalies (Kieser et al., 2003; Pueschel, 1990). DS most commonly arises as a result of an extra number 21 chromosome, and is also known as Trisomy 21. DS can also arise by translocation, mosaicism or partial Trisomy of chromosome 21 (Jyothy et al., 2002). DS has some unique characteristics that influence dental treatment for this population.

An anterior crossbite is a malocclusion in which one or more of the upper anterior teeth occlude lingually to the mandibular incisors. Anterior crossbites can be divided into three types:

1. Simple anterior crossbite (dental mal-position). There is a coincident centric occlusion and centric relation in a class I relationship. The maxillary incisor in crossbite is generally retroclined and the mandibular incisor may be proclined.

2. Functional anterior crossbite (pseudo class III). In this type there is an anterior displacement of the mandible on closure. In centric relationship the incisors are close to edge-to-edge contact, and as the mandible slides forward into centric occlusion, the incisors slip into crossbite.

3. Skeletal Class III anterior crossbite. These patients have a straight or concave facial profile in centric relation.

Simple anterior crossbite and functional crossbites may be caused by trauma to the primary dentition causing lingual displacement of the permanent tooth germ, over retained primary teeth, lack of space, supernumerary teeth, a bony or fibrous tissue barrier or habits such as lip biting (Ngan and Wei, 1988). For an anterior cross bite it is essential to correctly identify whether the malocclusion is a true skeletal class III malocclusion, or a pseudo class III caused by dental and functional abnormalities, as the treatment modalities are very different between the two.

A study by Jensen et al (1973) found an increased incidence of Class III malocclusions in DS individuals when compared to a control group. This was attributed to the following: an undeveloped maxilla, an enlarged anteriorly positioned tongue, or a prognathic mandible. They also found some form of crossbite in approximately 90% of the DS group, with anterior crossbites making up 20% in males and 10% in females. The mid face is more deficient than the mandible in DS patients. This is further exacerbated by a lack of vertical maxillary growth, resulting in the projecting of the mandible anteriorly (Desai and Fayetteville, 1997).

The purpose of interceptive orthodontic treatment is to eliminate or reduce the need for treatment in the permanent dentition (Kerosuo, 1999). This may also have the advantage of being considerably cheaper than fixed appliances. In uncooperative or disabled children, the crossbite is often left, which can lead to enamel damage, labial recession of the proclined lower incisors, tempromandibular joint pain and dysfunction. If functional crossbites are left untreated, they can encourage class III skeletal growth (Olsen, 1996).

The following case report is of a ten-year-old boy with DS who was treated using an upper removable appliance (URA) to correct a single tooth crossbite. It illustrates that sometimes our patients are capable of more than we think and that although challenging it can be also be very rewarding for patient and dentist.

Case Report

The patient was referred to the Hutt Hospital Dental Department, Wellington, New Zealand from a local private orthodontist for an assessment and treatment of his anterior crossbite of tooth 21 which was causing wear on the incisal edge. It was felt this treatment could not be provided by the orthodontist due to cooperation issues associated with the patient having DS.

The patient was a ten-year-old boy with DS and Hirschsprung's disease. He has had three previous general anaesthetics relating to his Hirschsprung's disease, with the last one being at six-years-old for a colostomy. He does not take regular medications, has no known allergies and his immunisations are up to date.

The patient lives with his mother, father and twin brothers who are eight-years-old. He attends his local primary school and has a full time teacher aid. The patient has been seen annually at the local School Dental Clinic for routine examinations. He has never required any dental restorations and has been cooperative for examinations, but not for radiographs.

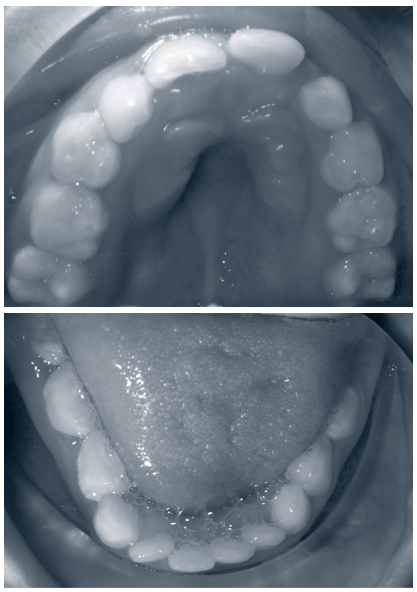
The patient lives rurally and drinks non-fluoridated tank water. His mother brushes his teeth twice a day with 1000ppm fluoride toothpaste.

Based on clinical assessment, study models, space analysis and radiological findings (Figs 1,2,3) the following diagnosis were made; low to medium risk of future dental caries, mild inflammation to lower incisor gingiva and bleeding on probing in all sextants, oral hygiene is average (plaque on lower incisors), limited cooperation due to DS, class II molar relationship occlusion due to missing maxillary lateral incisors, functional anterior crossbites of 21/31, 32; 63/73, space for all the permanent canine and premolar teeth to erupt, enamel defect and wear on tooth 21, congenitally absent teeth: 12, 22, 25.

Fig 1. Photograph of face

Fig 2. Intraoral photograph showing anterior crossbite and damage to 21

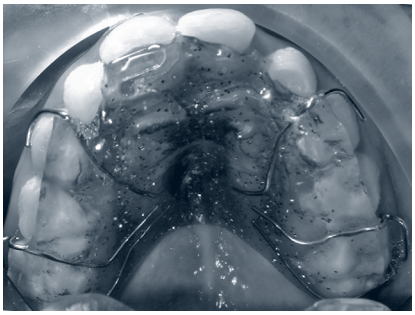
Fig 3. Intraoral views of upper and lower arches



After possible treatment options for correction of the crossbite were discussed, an appointment was made to see how he would cope with impressions. To his mother's surprise upper and lower impressions were taken with alginate and there was excellent cooperation with no signs of gagging, allowing the construction of an URA to correct the 21 crossbite.

At the try-in appointment the URA was inserted (Fig 4), the z spring activated and Adams clasps tightened. Although the patient was reluctant to wear URA initially he did leave the appointment wearing the appliance.

Fig 4. Appliance



The patient was reviewed in one week and he had been going very well with the URA and had been wearing it full time. In total the patient wore the appliance for just over three months and once tooth 21 was in a good position a composite strip crown to gain some additional over bite and improve aesthetics was planned.

At the restorative appointment the patient was still wearing the URA but tooth 64 which retained a c clasp, was mobile and close to exfoliation. A composite build up on 21 using a strip crown and composite was placed (Fig 5). However this was challenging as the patient would not allow suction or a slow speed hand piece to be used and no polishing or re-contouring of the restoration was possible. The mother was advised that the composite restoration might only last a limited time. The URA was adjusted and he was advised to keep wearing this for retention at night.

Fig 5. Anterior view showing correction with the crown of 21 lengthened with composite

Discussion

Children with DS also have an increased risk of congenital defects and organic disorders such as congenital heart and gastrointestinal defects, celiac disease, orthopaedic disorders, urinary tract disorders and hypothyroidism (Weijerman and de Winter, 2010). This patient has a congenital gastrointestinal defect, Hirschsprung's disease, which is commonly found in children with DS. Hirschsprung's disease is a disorder of the colon in which certain nerve cells, known as ganglion cells, are absent, causing chronic constipation (Worman and Ganiats, 1995). The patient had a colostomy to treat this when he was six years-old. Vision, hearing and throat disorders are also more prevalent in children with DS. This patient's hearing is normal; however he does wear glasses for reading. It is important that vision and hearing impairments are diagnosed and corrected early to maximise development in DS children (Weijerman and de Winter, 2010). DS children have a 18-38% prevalence of neuro-behavioural and psychiatric problems such as disruptive behaviour disorder, attention deficit disorder, depression, autism spectrum disorder and epilepsy (Weijerman and de Winter, 2010).

The main craniofacial features of DS are brachycephaly, flattened occiput and decreased length and flattening of cranial base (Hennequin et al., 1999; Fischer-Brandies, 1988). Some of the facial features associated with DS that our patient displayed were small, low set ears, small upturned nose, flattened nasal bridge, almond shaped eyes (Weijerman and de Winter, 2010). A characteristic facial feature of DS is the upward slanting palpebral fissures and epicanthic folds of the eyes (Kieser et al., 2003).

The patient displayed a number of the oral anomalies associated with DS including: hypodontia, shallow fissures on molars, malocclusion, relative macroglossia with forward position of the tongue and mild fissuring of the tongue. Delayed eruption of deciduous and permanent teeth, hypotonia, bruxism, mouth breathing, microdontia, enamel hypoplasia, short roots, decreased depth of palate and 'v' shaped palate can also be associated with DS (Rajic Mestrovic et al., 1998; Jensen et al., 1973). A common finding in DS individuals is a large protruding tongue; this may not always be a true macroglossia, but relative macroglossia, resulting from the combination of forward position of tongue due to hypotonia and lymphoid tissue at the tongue base and a small maxilla (Guimaraes et al., 2008; Limbrock, 1991). Hypodontia is more common among DS individuals (50%) when compared to general populations (2%) (Desai and Fayetteville, 1997) and this patient had three congenitally absent permanent teeth (12, 22, 25) and possibly his upper third molars.

Several studies have reported DS children having a lower experience of dental caries (Bradley and McAlister, 2004; Stabholz et al., 1991; Barnett et al., 1986; Cutress, 1971a). The lower prevalence of dental caries in earlier studies was thought to be

due to delayed eruption of permanent teeth, increased frequency of congenitally absent teeth, microdontia, and shallow fissures (Cutress, 1971a). When caries is present in DS children, 80% is found in posterior teeth pits and fissures (Barnett et al., 1986). This suggests that fissure sealing molar teeth in DS patients is recommended. In our case this was considered but cooperation, especially with the suction, was not yet present. In the meantime 6 monthly application of fluoride varnish will be continued (Zimmer, 2001).

Children with DS are predisposed to periodontal disease (Bradley and McAlister, 2004; Barnett et al., 1986; Cutress, 1971b). Several conditions may exacerbate periodontal disease such as crowding and poor occlusal relationship, particularly anterior and posterior crossbites. The forward position of the tongue produces more abnormal forces on the lower anterior teeth, which can be in crossbite, and can also contribute to periodontitis and early loss of the mandibular incisors (Shapira and Stabholz, 1996). This patient exhibited bleeding on probing in all sextants, but with no pocketing. Preventive management has included oral hygiene instruction, use of an electric toothbrush, intermittent use of chlorhexidine gel as well as fluoride applications. Although our patient is at the higher functioning end of the DS spectrum he still requires considerable support with tooth brushing. This was explained to his mother and an electric toothbrush, with a timer, was purchased to help facilitate better brushing.

Diagnosis and treatment of anterior crossbites can be more difficult in children with intellectual disability. Children with DS vary a lot in their ability to cope with procedures in the dental setting. Our patient coped better with the impressions and wearing of the URA than his mother had expected. The quality of the dentist – patient relationship is very important with DS children, and hence a trusting relationship needs to be nurtured (Hennequin et al, 1999). A good relationship has been established with the patient over the course of the treatment. With the help of his very supportive mother, he was very cooperative with impressions, bitewing radiographs, adjustments and wearing the URA. Further appointments to introduce slow speed and suction have been made and to date he has tolerated polishing two teeth with the prophy cup in the slow speed hand piece.

The patient was unable to wear the URA as a retainer due to the loss of retention after the exfoliation of clasped tooth 64 and the mobile 63. Relapse of the crossbite is a concern and will need to be monitored. It was predicted at the commencement of treatment that the outcome was uncertain, but it was agreed that the benefits would be significant and the treatment should be attempted. The management of orthodontic challenges in children with a disability can be difficult, but rewarding for them and the clinician when treatment is successful.

Congenitally absent teeth, especially missing lateral incisors, are always a challenge to the dentist and orthodontist. Compliance issues further complicated this in this case. The patient has already lost considerable space in his maxillary dentition. It is not known whether he had primary upper lateral incisors. It is preferable to encourage the 13 and 23 to erupt into the 12 and 22 spaces, as opening the space for implants would be impractical due to the amount of space lost, cost and compliance issues. The eruption of the 13 and 23 require future monitoring and timed extraction of 53 may be required in the future. If the crossbite relapses or the maxillary permanent canines erupt into crossbite, options of sectional orthodontic treatment or full arch fixed orthodontic treatment may be achievable depending on future compliance (Boyd et al., 2004).

References

- Barnett M, Press K, Friedman D, Sonnenberg E. The Prevalence of periodontitis and dental caries in a Down's syndrome population. J Periodontol 1986;57:288-293.
- Bradley C, McAlister T. The oral health of children with Down syndrome in Ireland. Spec Care Dentist 2004;24:55-60.
- Boyd D, Quick A, Murray C. The Down syndrome patient in dental practice, Part II: clinical considerations. NZ Dent J 2004;100:4-9.
- Cutress, TW. Dental caries in Trisomy 21. Archs Oral Biol 1971a;16:1329-1344.
- Cutress, TW. Periodontal disease and oral hygiene in Trisomy 21. Archs Oral Biol 1971b;16:1345-1355.
- Desai SS, Fayetteville NY. Down syndrome: a review of the literature. Oral Surg Oral Med Oral Pathol Oral Radiol Endod 1997;84:279-285.
- Fischer-Brandies H. Cephalometric comparison between children with and without Down syndrome. Eur J Orthod 1988;10:255-263.
- Guimaraes CVA, Donnelly LF, Shott SR, Amin RS, Kalra M. Relative rather than absolute macroglossia in patients with Down syndrome: implications for treatment of obstructive sleep apnea. Pediatr Radiol 2008;38:1062-1067.
- Hennequin M, Faulks D, Veyrune J-L, Bourdiol P. Significance of oral health in persons with Down syndrome: a literature review. Dev Med Child Neurol 1999;41:275-283.
- Jensen GM, Cleall JF, Yip ASG. Dentoalveolar morphology and development al changes in Down's syndrome (Trisomy 21). Am J Orthod 1973;64:607-618.
- Jyothy A, Mallikarjuna GN, Kumar K, Babu V, Uma B, Reddy PP. Translocation Down syndrome. Indian J Med Sci 2002;56: 225-229.
- Kerusuo H. The role of prevention and simple interceptive measures in reducing the need for orthodontic treatment. Med Principles Pract 1999;11:16-21.
- Kieser J A, Townsend G, Quick A. The Down syndrome patient in dental practice, Part I: Pathogenesis and general dental features. NZ Dent J 2003;99:5-9.
- Limbrock GJ, Fischer-Brandies H, Avalle C. Castillo-Morales' orofacial therapy: treatment of 67 children with Down syndrome. Dev Med Child Neurol 1991;33:296-303.
- Ngan P, Wei SHY. Early orthodontic treatment in the mixed dentition. In: Pediatric Dentistry: Total Patient Care. Wei SHY ed. Philadelphia: Lea & Febiger, 1988, pp. 471-490.
- Olsen CB. Anterior crossbite correction in uncooperative or disabled children. Case reports. Australian Dent J 1996;41:304-309.
- Pueschel SM. Clinical aspects of Down syndrome from infancy to adulthood. Am J M Gen 1990; Suppl 7:52-56.
- Rajic Mestrovic S, Rajic Z, Stefanac Papic J. Hypodontia in patients with Down's syndrome. Coll Antropol 1998;22:69-72.
- Shapira J, Stabholz A. A comprehensive 30-month prevention dental health program in a pre-adolescent population with Down's syndrome: A longitudinal study. Special Care Dent 1996;16:31-37.
- Stabholz, A, Mann J, Sela M, Schurr D, Steinburg D, Dori S, Shapira J. Caries experience, periodontal treatment needs, salivary pH, and Steptococcus mutans counts in a preadolescent Down syndrome population. Spec Care Dent 1991;11:203-208.
- Wejierman ME, de Winter JP. The care of children with Down syndrome. Eur J Pediatr 2010;169:1445-1452.
- Worman S, Ganiats TG. Hirschsprung's disease: a cause of chronic constipation in children. Am Fam Physician 1995:51:487-494.
- Zimmer S. Caries preventive effects of fluoride products when used in conjunction with fluoride dentifrice. Caries Res 2001;35:18-21.

IAPD

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The Bright Smiles-Bright Futures Award

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RULES

1. The name of the Prize is to be the Bright Smiles-Bright Futures Award and is offered at each IAPD Biennial Congress.
2. The value of the Prize is to be 2000 US Dollars. In addition, there will be a further 3 classified winners who will each win 500 US dollars.
3. The Prize is open to any **IAPD individual member or organization** (at least one member of the team must be an IAPD individual member) responsible for creating or implementing a preventive oral health community programme serving children. The Prize will be awarded for the most meritorious essay. It will be judged by an international panel of adjudicators.
4. Registration at the Congress is a requirement for competition entry
5. Entry forms are obtained from the Association Co-ordinator Mrs Sylvie Dutilloy at the IAPD Secretariat.
6. All entries are to be sent **electronically** to iapd@iapdworld.org.unless otherwise stated to the IAPD Secretariat (or an alternative address that is provided) in a final and completed version before the deadline established for each Congress
7. All entries have to be accompanied with a completed Award application form
8. The International Association of Paediatric Dentistry reserves the right of publication of the prize-winning essay.
9. The essay must be submitted by **31 January 2015** to the IAPD secretariat:

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Telephone: +41 (0)22 560 81 50 – Fax: +41 (0)22 560 81 40 –
E-mail : iapd@iapdworld.org.

Management of an Adolescent with Frontonasal Dysplasia and Dental Anomalies

Niveathanan Kamalendran, Third Year DClin Dent Student

Supervisors: Prof Bernadette Drummond, Ms Winifred Harding

Introduction

Sedano first described 'Frontonasal Dysplasia' 1970. Frontonasal dysplasia (FND) is a rare disorder characterized by mild or severe abnormalities of the head and face, especially the forehead, nose and central portion of the upper lip[1]. Occasionally, there are also abnormalities found in the brain, heart and some bones. In severe cases, mild to moderate retardation may be present. Many other terms have been used to describe this disorder including 'median cleft face syndrome'[2], Cohen syndrome[3], Frontonasal Dysostosis[4], Frontonasal syndrome[5] and Cranio-frontonasal dysplasia[6]. However Front-onasal Dysplasia has remained the most widely used and accepted description in the literature.

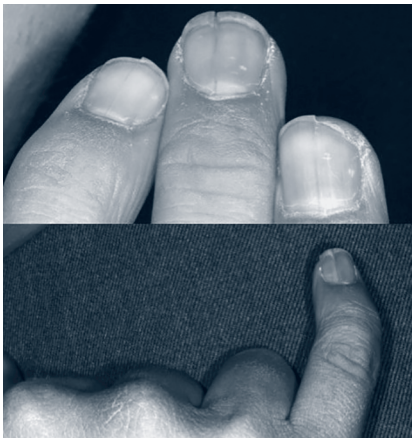
The characteristic features of FND are orbital hypertelorism; broadening of the nasal root; median facial cleft affecting the nose, upper lip, and palate; uni or bilateral clefting of the alae nasi; lack of formation of the nasal tip[1]. In addition, curly hair, grooved nails, anterior cranium bifidum occultum, downward slanting of palpebral fissures and a V-shaped prolongation of the hair onto the forehead (widow's peak) are included in the features. This condition may also may be associated with congenital heart abnormalities, in particular, Tetralogy of Fallot [7]. Other common clinical features include vertebral anomalies [8], short neck, short limbs, clindodactyly of the fifth finger, and/or polydactyly of the hands and feet [4, 9, 10]. These abnormalities can be present in any combination depending on the severity of presentation. Oral anomalies that may be found in patients with FND are micrognathia [11], high arched palate [12], hypoplastic maxilla [13], cleft lip and palate [2], hypoplastic/hypomineralized enamel [14] and/or abnormalities in tongue development [15]. This case report describes a rare case of young boy diagnosed with Frontonasal Dysplasia and the associated oral anomalies. It also discusses the multidisciplinary management of the supernumerary teeth and anterior crossbite he presented with.

Case Report

Fig 1. Face and head showing curly hair, orbital hypertelorism, broad nasal tip, bifid nose, downward slanting of palpebral fissures

A 13-year old boy was referred to the University of Otago Paediatric Dentistry Clinic for management of an anterior crossbite and upper and lower anterior supernumerary teeth. The medical history revealed that he was diagnosed as having Frontonasal Dysplasia at the age of three years. There was no history of a similar family condition. He had undergone surgery to correct orbital hyperterlorism and bifid nose when he was nine years old. On examination it was noted that he had curly hair, a degree of orbital hypertelorism, a broad nasal tip, partially bifid nose and downward slanting palpebral fissures (Fig 1).

Fig 2. Hand and fingers showing grooved nails and clindodactyly of the fifth finger



His fingernails were grooved and he had clindodactyly of the fifth finger of each hand (Fig 2). Intra oral examination revealed a permanent supernumerary supplemental upper incisor, a permanent mandibular supernumerary supplemental right central incisor (Fig 3) and an anterior crossbite involving 11 and 42 (Figure 4). Mild lower anterior crowding was also noted. A panoramic radiograph (Figure 5) showed presence of all permanent teeth and the supernumerary teeth.

Fig 3. Intraoral view showing maxillary supernumerary tooth in midline and lower anterior supernumerary tooth

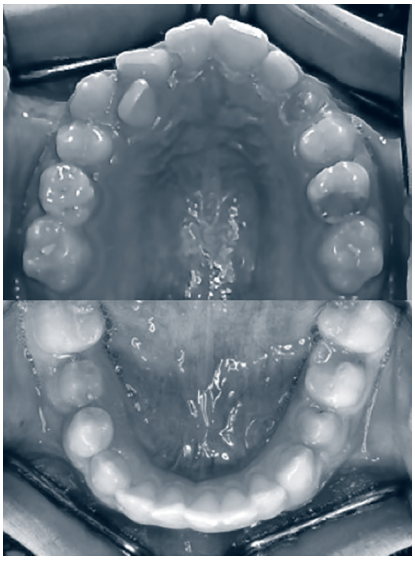
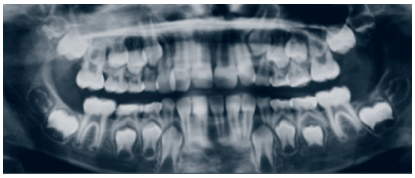


Fig 4. Intraoral anterior view showing crossbite of 11 and 42

Fig 5. Panaromic radiograph



The treatment objectives established with Paediatric Dentistry and Orthodontics

were to: correct the anterior crossbite, establish normal overbite and overjet, align the anterior teeth for ideal inclination and improve the patient's dental aesthetics. As the patient was caries-free with healthy periodontal tissues, his usual prevention was reinforced. To establish a good anterior occlusion and after measuring space and teeth sizes, the tooth between 11 and 21 was extracted (Fig 3). This tooth was narrower in width than the 21. This was followed by fixed orthodontic treatment to correct the anterior crossbite and close space. The lower supernumerary tooth was not extracted. All the lower anterior teeth were disked with a fine diamond to correct the lower anterior crowding. The treatment plan and alternatives were explained to the patient and his parents who provided their written consent prior to treatment.

The extraction of the supernumerary tooth was carried out under local anesthesia and orthodontic treatment was started three days after the extraction. Orthodontic treatment is ongoing.

Discussion

Frontonasal dysplasia (FND) also described as median facial cleft, frontonasal dysostosis or malformation, is an unusual congenital anomaly. The pathogenesis is unknown and the majority of FND cases are sporadic[10]. Some studies describe the genetic aetiology involving the ALX4 genes[16]. The diagnosis of FND is made at birth or by prenatal ultrasound [13] and is based on the observed facial abnormalities. This condition may also be seen as part of other syndromes including oculoauriculofrontonasal syndrome [17], Pai syndrome [18] and acromelic frontonasal dysplasia [19]. The prevalence rate is unknown and the Office of Rare Diseases (ORD) of the National Institute of Health (NIH) has listed this as a rare disease.

There are several classification systems for FND, but the Sedano and Jirasek [1] classification is used most often. This classification, based on the embryological aetiology is classified into four types:

Facies A includes orbital hypertelorism, broad nasal root and median nasal groove with absence of the nasal tip.

Facies B includes orbital hypertelorism, broad nasal root with a median facial groove or cleft that affects the nose or the nose and upper lip and/or palate.

Facies C includes orbital hypertelorism, broad nasal root and unilateral or bilateral notching.

Facies D is a combination of Facies B and C.

The present case has been diagnosed as Facies A which is the milder form of this syndrome. The clinical findings of FND, although present at birth, may be missed or diagnosed at a much later time. Physicians through incidental findings in treatment for unrelated conditions diagnose some cases. Most children with FND are of normal intelligence [20]. The risk of severe mental retardation is reported as 8% [21]. Children with FND may have a poor quality of life because of their facial abnormalities [22] and this case initially had a poor quality of life in school until he had surgery at age 7 years to improve his facial appearance.

The differential diagnoses of FND include frontofacionasal dysplasia (FFND), which has ocular defects and midface hypoplasia in addition to the midline facial cleft [23]. Acro-frontofacionasal dysostosis is distinguished from FND by the presence of campto-brachy-polysyndactyly and limb hypoplasia [4]. Craniofrontonasal dysplasia is characterized by the presence of coronal synostosis, as opposed to a bifid cranium in FND[24]. Intraoral anomalies associated with FND have not been studied in detail. A few reports have noted migronathia, high arched palate, hypodontia and hypoplastic enamel [14, 25, 26]. No previous reports of supernumerary teeth have been identified and the presence of supernumeraries in this case may be a new dental finding.

Conclusion

Frontonasal Dysplasia is a rare condition with few reports of associated oral anomalies. Dentists should be aware of possible dental implications that can appear with this syndrome and form part of the multidisciplinary team managing the anomalies. Dentists finding anomalies in any unusual syndrome should inform the pediatrician so that this can be added to the patient's medical records. Early diagnosis and multidisciplinary management of FND can improve the quality of life of patients with this condition.

References

1. Sedano HO, Cohen MM Jr, Jirasek J, Gorlin RJ. Frontonasal dysplasia. Journal of Pediatrics 1970;76:906-913.
2. Gupta H, Gupta P. Median cleft face syndrome. Indian Pediatrics 2004;41:90-90.
3. Cohen MM Jr. Craniofrontonasal dysplasia. Birth Defects Original Article Series 1979;15(5B):85-89.
4. Nevin NC, Leonard AG, Jones B. Frontonasal dysostosis in two successive generations. American Journal of Medical Genetics 1999;87:251-253.
5. Rosasco SA, Massa JL. Frontonasal syndrome. British Journal of Plastic Surgery 1968;21:244-249.
6. Saavedra D, Richieri-Costa A, Guion-Almeida ML, Cohen MM Jr. Craniofrontonasal syndrome: study of 41 patients. American Journal of Medical Genetics 1996;61:147-151.
7. De Moor M, Baruch R, Human D. Frontonasal dysplasia associated with Tetralogy of Fallot. Journal of Medical Genetics 1987;24:107-109.
8. Lees MM, Hodgkins P, Reardon W, Taylor D, et al. Frontonasal dysplasia with optic disc anomalies and other midline craniofacial defects: a report of six cases. Clinical Dysmorphology 1998;7:157-162.
9. da Silva Lopes VLG, Guion-Almeida ML, Giffoni SDA. Frontonasal dysplasia, neuronal migration error and lymphoedema of limbs. Clinical Dysmorphology, 2004;13:35-37.
10. Guion-Almeida ML, Richieri-Costa A, Saavedra D, Cohen MM Jr. Frontonasal dysplasia: analysis of 21 cases and literature review. International Journal of Oral and Maxillofacial Surgery 1996;25:91-97.
11. Edwards W, Askew W, Weisskopf B. Median cleft face syndrome. American Journal of Ophthalmology 1971;72:202-205.
12. Toriello HV, Radecki LL, Sharda J, Looyenga D, Mann R. Frontonasal "dysplasia," cerebral anomalies, and polydactyly: report of a new syndrome and discussion from a developmental field perspective. American Journal of Medical Genetics, 1986;25:89-96.
13. Martinelli P, Russo R, Agangi A, Paladini D. Prenatal ultrasound diagnosis of frontonasal dysplasia. Prenatal Diagnosis 2002;22:375-379.
14. McCann M. McCann K. Frontonasal dysplasia and its orodental aspects. Journal of Dentistry 1973;2:69-71.
15. Hamon-Kérautret M, Ares GS, Demondion X, Rouland V, Francke JP, Pruvo JP. Duplication of the pituitary gland in a newborn with median cleft face syndrome and nasal teratoma. Pediatric Radiology 1998;28:290-292.
16. Uz E, Alanay Y, Aktas D, Vargel I, et al. Disruption of ALX1 causes extreme microphthalmia and severe facial clefting: expanding the spectrum of autosomal-recessive ALX-related frontonasal dysplasia. American Journal of Human Genetics 2010;86:789-796.
17. Cohen MM Jr, Rollnick BR, Kaye CI. Oculoauriculovertebral spectrum: an

updated critique. Cleft Palate Journal 1989;26:276-286.

18. Vaccarella F, Pini Prato A, Fasciolo A, Pisano M, et al. Phenotypic variability of Pai syndrome: report of two patients and review of the literature. International Journal of Oral and Maxillofacial Surgery 2008;37:1059-1064.
19. Slaney SF, Goodman FR, Eilers-Walshman BL, Hall BD, et al. Acromelic frontonasal dysostosis. American Journal of Medical Genetics 1999;83:109-116.
20. Guerrini R, Dobyns WB. Bilateral periventricular nodular heterotopia with mental retardation and frontonasal malformation. Neurology 1998;51:499-503.
21. Stevenson RE, Procopio-Allen AM, Schroer RJ, Collins JS. Genetic syndromes among individuals with mental retardation. American Journal of Medical Genetics A 2003;123:29-32.
22. Rédei GP. Frontonasal Dysplasia. In: Encyclopedia of Genetics, Genomics, Proteomics and Informatic. Springer: 3rd edition, 2008, p. 716-716.
23. Gollop TR, Kiota MM, Martins RM, Lucchesi EA, Alvarenga Filho E. Frontofacionasal dysplasia: evidence for autosomal recessive inheritance. American Journal of Medical Genetics 1984;19:301-305.
24. Lorenz P, Prager B, Tellkamp H. Frontonasal dysplasia. Case report and review of the literature. Kinderarztliche Praxis 1990;58:415-420.
25. Sedano HO, Gorlin RJ. Frontonasal malformation as a field defect and in syndromic associations. Oral Surgery Oral Medicine Oral Pathology 1988;65:704-710.
26. Lynch SA, Hall K, Precious S, Wilkies AO, Hurst JA. Two further cases of Sener syndrome: frontonasal dysplasia and dilated Virchow-Robin spaces. Journal of Medical Genetics 2000;37:466-470.

ANZSPD Secretary / Manager's Report

Greetings again from the Secretary / Manager

Peter Gregory
Secretary / Manager, ANZSPD (Inc.)

Hope all is well in your part of the world.

The Executive continues to be very active in many areas of the management of our organisation.

Website. The launch of the new ANZSPD website is imminent. This has been an enormous task, and John Winters must be congratulated on his efforts in bringing this project to its fruition. Acknowledgement also must be extended to the army of people that John has mustered to provide content for the website. Because it is an interactive website, it is far more complex than just setting up a static one. New inclusions will certainly make the tasks of Branch Secretaries, Treasurers and the Federal Secretary/Manager, much easier and less time consuming. Most importantly, however, the members will benefit most from the new innovations that have now been included.

Annual General Meeting. The 2014 AGM of the Society was held at the Pullman Resort, Bunker Bay, WA, in July, to coincide with the visit of the Federal President, Dr John Sheahan, to the WA Branch. The minutes of this meeting have been previously circulated.

Next ANZSPD Biennial Meeting. Dr Michael Malandris and his energetic and hard working team are busy planning what will be an excellent scientific and social event in Adelaide, SA in November 2015. The next AGM of the Society will be held in conjunction with this meeting.

Federal Council Meeting. The next Federal Council Meeting of the Society will be held early next year at a time and place to be determined. Urgent business and voting is still conducted via email, to ensure that decisions are made in a timely manner.

Constitutional Changes. The Federal ANZSPD (Inc.) Constitution has not been overhauled for years. It may not even now comply with the WA Regulatory Authorities. It is planned that a re-vamped constitution will be ready for voting at the next AGM in Adelaide in November 2015. If you have any issues with the current FEDERAL ANZSPD (Inc,) Constitution and wish to propose changes, please forward them to me in the form of a motion, duly seconded so they can be appropriately circulated prior to the meeting.

International Association of Paediatric Dentistry (IAPD). The next IAPD congress is to be held in Glasgow, Scotland from 1st-4th July 2015. As a member nation of IAPD it is encumbant on us to offer any support we can, and particularly with our attendance. The very hard working, energetic and extremely active organising committee will produce an excellent event in a unique surrounding.

Please mark you diaries now.

Acknowledgements. I wish to again acknowledge the role the Federal President, Dr John Sheahan, is playing in leading our organisation. It is over 30 years since I was President and I can see just how much additional work and effort is required these days. I would also like to thank the Federal Councillors, Branch Executive and the members of our organisation for their continuing support. Special thanks must go to Susan Cartwright and her wonderful team at Colgate, for their never-ending support and sponsorship.

Best wishes and good health to all.

ANZSPD Victorian Branch Report

Dr Evelyn Yeung

Vice-President, ANZSPD Victorian Branch

The ANZSPD Victorian Branch has had a busy year to date- as we commenced our annual program by hosting the RK Hall Lecture Series that was proudly sponsored by Colgate. This event was held on the 28th of February and 1st of March 2014 at the Sofitel Melbourne. We were fortunate to have two eminent guest speakers to provide enriching presentations that were well received by all those in attendance. Professor Svante Twetman from the University of Copenhagen in Denmark enlightened the audience with his dynamic presentations on 'Caries as a biofilm-mediated disease in childhood', 'Caries risk assessment in children', and 'Evidence for the preventive strategies through traditional and novel approaches'. The role of pulp therapy in the primary and immature permanent dentition, as well as an update on dental trauma management was provided by Associate Professor Michael Casas from the Hospital for Sick Children in Toronto, Canada. We were fortunate to have the honour of Professor Roger Hall addressing the delegates with his reflection on what has been achieved in paediatric dentistry since the inaugural RK Hall Lecture Series held in Melbourne in 1998, and the possibilities to come.

The RK Hall Lecture series was well attended by general practitioners, dental specialists and dental auxiliaries from Australia and New Zealand. It was an occasion where members of our society and profession were able to celebrate and reflect on the life achievements of Dr Alistair Devlin at his memorial, and we were privileged that his widow, Helen and son Richard, were able to join us for his tribute.

The ANZSPD Victorian Branch held their second event on the 17th of July through a joint dinner meeting with the Australian Society of Periodontics- Victorian Branch at the Woodward Conference Centre. Whilst admiring the amazing view of the Melbourne city night scape, the dinner and lecture guests were well informed about the evening's topic of "Getting to the root of the matter: Joint Paediatric and Periodontic Management". We were fortunate to have presentations by Clinical Associate Professor Kerrod Hallet and Associate Professor Werner Bischof that highlighted the multidisciplinary approach for the complex management of periodontal conditions in paediatric patients.

Our final event for 2014 will be held on the 18th of October at the Jean Faulkner Lecture Theatre, at the Royal Dental Hospital of Melbourne. We are looking forward to this meeting which will explore "Restorative management in paediatric dentistry" through presentations by Professor David Manton, Dr Mala Desai and Dr Lochana Ramalingam. Additionally Dr Chris Bolton will explore the topic of "General anaesthesia for paediatric dental management".

ANZSPD New South Wales Branch Report

Dr Michele Tjeuw
Secretary ANZSPD
New South Wales Branch

ANZSPD NSW Branch has enjoyed another fruitful year of continuing education and professional development.

We have continued to broaden our horizons through our dinner meetings. At our first meeting, we learnt from Dr Kristy Goodwin who shared with us the positive potential digital media brings to support the delivery of dental services to families and young children. It was interesting to hear about how digital technologies are shaping the iGeneration's development and learn about techniques to leverage technologies in delivering dental services.

Our group interest in ENT issues was explored further in our next meeting with the topic of Bruxism, Chronic Airway Obstruction and Orthodontic- related problems. Dr Ronny Marks presented an update on the relationship between bruxism and chronic airway obstruction in the paediatric population and Dr Bill Johnston further discussed the implications from an ENT perspective.

We look forward to our final dinner meeting where we will look at Newborn Feeding Issues. Ms Melissa Compton (Speech Pathologist) will share her knowledge on Oro-motor function and tongue ties and Ms Linda Hayes (Clinical Psychologist) will be presenting on Peri-natal support for feeding, settling and sleeping difficulties.

Under the leadership of Dr Chinh Nguyen, we have revisited the Constitution and accepted the new format in its entirety. Dr Naveen Loganathan has worked tirelessly in settling the accounts and Dr Soni Stephen has kept us up to date with the Federal issues. Together, we have worked seamlessly to organise the meetings and encourage membership into the NSW Branch.

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Welcome to the Website

Dental professionals caring for children's oral health

Welcome to the new website of the Australian and New Zealand Society of Paediatric Dentistry (ANZSPD). The Society is justly proud of it.

ANZSPD is already Australasia's principal and most respected supplier of continuing professional development courses in Paediatric Dentistry. In time, I trust this website will become Australasia's premier paediatric dental resource for parents, dental practitioners and members alike. Please take the time to make yourself familiar with it because it is already packed with news and information to help keep you up to date on the world of Paediatric Dentistry.

This website will be far more dynamic than ANZSPD's previous website, so it is important to return to it time and time again to keep abreast of the latest in paediatric dental advice, where to find a member and upcoming continuing education courses in Paediatric Dentistry, both in your local area and further afield. ANZSPD has always been keen to improve its service to the profession and the broader community. To this end, ANZSPD would welcome your feedback about the website or any of ANZSPD's other activities.

On behalf of ANZSPD, I would like to thank Dr John Winters who has worked tirelessly to facilitate the development of the new website and all the members who have contributed in any way to the available content.

So now it's time to explore what we have on offer!

With kind regards,

Dr John M Sheahan
Federal President
ANZSPD Inc.

Events

- Dentistry for the Adoles... — Friday, 7 November 2014
- RACDS 2014 Joint Collegi... — Sunday, 7 December 2014
- ADA 36th Australian Dent... — Wednesday, 25 March 2015
- EAPD 9th European Academ... — Friday, 8 May 2015
- AmAPD 2015 Annual Meetin... — Thursday, 21 May 2015
- IAPD 2015 The Voice of t... — Wednesday, 1 July 2015
- NZDA Conference 2015 — Wednesday, 19 August 2015
- AAPD 25th Anniversary Me... — Wednesday, 11 November 2015

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Affiliations

ADA Australian Dental Association Inc. | New Zealand Dental Association | IAPD National Member Society | The D3 Group | AAPD

Latest news

- **Keep the Date Free** — Monday, 22 September 2014
- **Welcome to the Website** — Monday, 22 September 2014

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Colgate® Corner

by Sue Cartwright,
BDS, Dip Clin Dent, M Ed

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In vitro Study of the Effect of a Dentifrice Containing 8% Arginine, Calcium Carbonate & Sodium Monofluorophosphate on Acid-Softened Enamel (Rege et al) (J Clin Dent 2014;25(Spec Iss A):A3-6)

A series of in vitro experiments demonstrated a possible mode of action by which a dentifrice containing 8% arginine, calcium carbonate & sodium monofluorophosphate delivers the benefits of preventing acid erosion and rehardening acid-softened enamel. The combination of arginine and calcium carbonate adheres to the enamel surface and helps to fill the microscopic gaps created by acid, which in turns helps repair the enamel and provides a protective coating against future acid attacks.

Evaluation of a Dentifrice Containing 8% Arginine, Calcium Carbonate & Sodium Monofluorophosphate (MFP) to Prevent Enamel Loss After Erosive Challenges Using an Intra-Oral Erosion Model (R.Sullivan et al) (J Clin Dent 2014;25(Spec Iss A):A7-13)

The test dentifrice with 8% arginine, calcium carbonate & 1450 ppm fluoride as MFP provided significantly better protection against ex-vivo erosive challenges in comparison to the control dentifrice with 1450 ppm fluoride as MFP during this intra-oral erosion study.

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1-4th July 2015
IAPD International Congress
"The voice of the child"
Glasgow. UK.
www.iapdworld.org
www.iapd2015.org

9th EAPD Interim Seminar and Workshop
8-9th May 2015
Brussels. Belgium
www.eapd.rg

21-24 May 2015
American Academy of Pediatric Dentistry Annual Session.
Seattle USA
www.aapd.org

19-22 August 2015
New Zealand Dental Association Conference
Aukland New Zealand

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www.nzda.org.nz/pub/index.php?id=210#20158

2-5th June 2016
13th EAPD Congress
Belgrade. Serbia
www.eapd.rg

26th IAPD International Congress 2017
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Federal President	Dr John Sheahan federal.president@anzspd.org.au
Vice President	Dr Tim Johnston timjohnston@westnet.com.au
Hon Secretary/Treasurer	Dr Peter Gregory federal.secretarymanager@anzspd.org.au
Immediate Past President	Dr Kareen Mekertichian ksmekj@bigpond.net.au

Branch Executives

Branch	President	Secretary	Fed Councillor
NZ	Dr Heather Anderson russell.heather@xtra.co.nz	Dr Craig Waterhouse craig.shona@xtra.co.nz	Dr Erin Mahoney erinkm@slingshot.co.nz
NSW	Dr Chinh Nguyen chinhn@optusnet.com.au	Dr Michele Tjeuw anzspd.nsw@gmail.com	Dr Soni Stephen soni.stephen@southsidepd.com.au
QLD	Dr P.Y. Lai twinklelittlestar@kidsdental.com.au	Dr Steve Kazoullis steven@kazoullis.com	Dr Sue Taji drsuetaji@qdg4kids.com.au
SA	Dr Michael Malandris manjmichael@gmail.com	Dr Wendy Cheung wendywsc@hotmail.com	Dr PJW Verco joverco@verco.com.au
VIC	Dr Amy Fung amy1fung@yahoo.com	Dr Giselle D'Mello secretary.anzspdvb@gmail.com	Dr John Sheahan johnsheahan@bigpond.com
WA	Dr Peter Readman drpeter@iinet.net.au	Dr Rod Jennings anzspdwa@gmail.com	Dr Tim Johnston timjohnston@westnet.com.au

Editor Synopses	Timothy Johnston timjohnston@westnet.com.au
Correspondence	Timothy Johnston The Editor, Synopses 8 Thelma Street West Perth WA 6005 AUSTRALIA
Artwork, printing and distribution	Colgate®
	Colgate Oral Care Level 15, 345 George Street Sydney NSW 2000 AUSTRALIA

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Submissions

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